STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814
(916) 322-0181

December 16, 1981

ALL-COUNTY LETTER NO. 81-127

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: DISABLED UNION V. WOODS

REFERENCE:

On December 7, 1981, a Modified Preliminary Injunction was issued in the case of Disabled Union vs. Woods by Judge Leon Savitch of the Los Angeles Superior Court.

I. The Modified Preliminary Injunction requires that the defendants do the following:

1. Not terminate or reduce IHSS grants pursuant to the form notices in controversy;

2. Not deny a hearing to any IHSS recipient who properly and timely requests a hearing;

3. Provide aid paid pending state hearings;

4. Utilize the court approved special notices of reduction or termination for able and available spouse, domestic services and heavy cleaning;

5. Severely impaired recipients are to continue to receive benefits as ordered in the Temporary Restraining Order (TRO) until future reductions are made consistent with the notices to the non-severely impaired; and

6. Notify the counties and other relevant parties regarding the provisions of the injunction.

II. In order to comply with the Preliminary Injunction and to make reductions to non-severely impaired recipients of IHSS, you are required to do the following:

1. Issue the appropriate one or more of the attached notices to all non-severely impaired recipients who received a previous

"SB 633" notice which has been invalidated by the court and who have not requested a state hearing.

It will be necessary to utilize more than one special notice if multiple "SB 633" actions were taken;

2. The special notices of action must be issued immediately. Final case processing must be completed and special notices mailed to all affected recipients no later than January 20, 1982. Counties which can process and issue these notices before this date are instructed to do so;

3. Recipients are entitled to, and will receive a state hearing if their request is filed within 90 days following the mailing date of the special notice;

4. Recipients requesting a hearing within 10 days of the mailing date of the special notice are to receive aid paid pending the hearing from the date of the original action;

5. Not reduce or terminate services in applying the able and available spouse regulations if the eligible recipient would, in the absence of service, become unemployed or be placed in a medical out-of-home care facility. Not reduce or terminate services in applying the domestic service and heavy cleaning regulations if the eligible recipient would, in the absence of such service, be placed in a medical out-of-home care facility; become unemployed; be placed in a life threatening situation; or in conditions presenting a substantial threat to the recipient's health or safety;

6. For specific information on hearing procedures and aid paid pending state hearings for all non-severely impaired recipients who requested state hearings under the original "SB 633" notice refer to All-County Letter (ACL) #81-123; and

7. Reproduce the attached special notices which have been approved by the court. There can be no variation in wording, printing or format. There will be no exceptions granted by the state for use of other than the attached forms. Translated notices as required by law are available upon request by contacting the DSS Language Services Unit at (916) 323-9562.

III. In order to make reductions to severely impaired recipients of IHSS, you must do the following:

1. Issue the appropriate one or more notices to all severely impaired recipients of IHSS who were fully restored to their previous level of service pursuant to the TRO and who did not request a state hearing.

It will be necessary to utilize more than one notice if multiple "SB 633" actions were taken;

3. Recipients are entitled to, and will receive a state hearing if their request is filed within 90 days following the mailing date of the notice;

4. Recipients requesting a hearing before the effective date of the action are entitled to aid paid pending;

5. Not reduce or terminate services in applying the able and available spouse regulations if the eligible recipient would, in the absence of service, become unemployed or be placed in a medical out-of-home care facility. Not reduce or terminate services in applying the domestic service and heavy cleaning regulations if the eligible recipient would, in the absence of such service, be placed in a medical out-of-home care facility; become unemployed; be placed in a life threatening situation; or in conditions presenting a substantial threat to the recipient's health or safety;

6. For specific information on hearing procedures and aid paid pending state hearings for all severely impaired recipients who requested state hearings under the original "SB 633" notice, refer to ACL #81-123; and

7. Reproduce the attached notices which have been approved by the court. There can be no variation in wording, printing or format. There will be no exceptions granted by the state for use of other than the attached forms. Translated notices as required by law are available upon request by contacting the DSS Language Services Unit at (916) 323-9562.

Attached are additional instructions on how to process payments for individual provider cases. Also attached is a description of forms to be used in each case. If you have any questions about these instructions, contact your consultant in the Adult Services Program Operations Bureau at (916) 445-8724.

Sincerely,

CLAUDE E. FINN
Deputy Director

Attachments

cc: CWDA

IN—HOME SUPPORTIVE SERVICES (IHSS)

NOTICE OF ACTION

NOTE: *The action described below relates **ONLY** to your Social Services. It does **NOT** affect your receipt of SSI/SSP or Social Security*

Case Number: _____

Date Mailed: _____

SPECIAL NOTICE

This is a special notice which is being sent to you concerning your In-Home Supportive Services. On _____ you were sent a notice from the county welfare department which either reduced or terminated your In-Home Supportive Services due to a change in State law. **That notice may not have properly and completely informed you of your right to request a state hearing and of your right to receive aid paid pending the state hearing.** PLEASE CAREFULLY READ ALL OF THE FOLLOWING NOTICE WHICH WILL GIVE YOU INFORMATION ON THE NATURE OF THE COUNTY WELFARE DEPARTMENT'S ACTION AND ITS EFFECT ON YOUR IN-HOME SUPPORTIVE SERVICES. If you have any questions after reading this information or believe other facts should be considered, please immediately call your Agency Representative.

Your In-Home Supportive Services (IHSS) were reduced to _____ hours ($ _____) per month effective _____ . Prior to this reduction, you received _____ hours ($ _____) per month. The changes were as follows:

	Hours per month now allowed	**Hours per month before reduction**
Domestic services: (Such as sweeping, garbage removal, putting away food and changing bed linen.)	_____	_____
Related services: (Those services related to domestic, such as shopping, preparation of meals and cleanup and laundry.)	_____	_____
Transportation: (Such as transportation to necessary medical appointments and other necessary travel.)	_____	_____
Protective Supervision: (Observing behavior in order to safeguard against injury or accident.)	_____	_____
Other: (specify) _____	_____	_____

The county welfare department has determined that:

1. You have a spouse living in your home;
2. Your spouse does not have medical verification of inability to perform services;
3. Your spouse is not away from your home for employment or for health reasons during the time that meal preparation, transportation and protective supervision are required;
4. This reduction would not result in your loss of employment or placement in a medical out-of-home care facility.

This reduction is the result of a new state regulation. This regulation requires that when an able spouse in the home is available to assist you, the state cannot pay your spouse or any other provider for any IHSS services other than nonmedical services and paramedical services. (Nonmedical personal services are services such as bowel and bladder care, feeding, routine bed baths and dressing. Paramedical services are services which are ordered by a licensed health care professional.)

The above action was required by regulation MPP Section 30-463.24.

IF YOU DISAGREE WITH THE DETERMINATION WHICH RESULTED IN THE REDUCTION OR TERMINATION OF YOUR IHSS, SEE THE REVERSE SIDE OF THIS FORM FOR YOUR RIGHT TO REQUEST A STATE HEARING AND TO RECEIVE AID PAID PENDING THE HEARING.

_____ Agency Representative

_____ Telephone Number

Your Right to Appeal This Action

If you are dissatisfied with the County's original action, you may request a state hearing before a Hearing Officer of the State Department of Social Services even though your original notice may have led you to believe otherwise. This hearing will be conducted in an informal manner to assure that everyone present is able to speak freely. If you decide to request a state hearing, you may do so within **90 DAYS OF THE MAILING OF THIS NOTICE.**

IF YOU ASK FOR A HEARING WITHIN 10 DAYS OF THE MAILING DATE OF THIS NOTICE, YOU WILL RECEIVE AID PAID PENDING THE STATE HEARING, AT THE LEVEL OF SERVICES YOU RECEIVED BEFORE THE COUNTY'S ORIGINAL ACTION.

Aid paid pending will be effective as of the date of the County's original action.

You will not be liable for repayment of services or monies received pending the hearing, even if the result is a denial.

You can represent yourself at the state hearing. You can also be represented by a friend, attorney or any other person, but you are expected to arrange for the representative yo[illegible] get help in locating free legal assistance by calling the toll-free number of Public Inquiry and Response.

How to Request a State Hearing

The best way to request a hearing is to fill in and send this entire notice to:

Office of the Chief Referee
State Department of Social Services
744 P Street, Mail Station 6-100
Sacramento, CA 95814

You may also request a hearing by calling the toll-free number of Public Inquiry and Response.

Public Inquiry and Response (Public Information)

Toll-Free Number: (800) 952-5253 *

TDD (800) 952-8349* For the Deaf Only

*You may have to dial "1" first.

The State Public Inquiry and Response Unit can provide you with further information about your hearing rights or files or other welfare-related matters. Assistance is also available in some languages other than English, including Spanish. You may phone, write, or come in.

Public Inquiry and Response
State Department of Social Services
744 P Street, Mail Station 16-23
Sacramento, CA 95814

Request for a State Hearing

Name _____ Phone number ( )

Address _____ City _____ State _____ Zip code

I am requesting a state hearing because of an action by the welfare department of _____ county related to In-Home Supportive Services

Reasons for my request:

☐ I speak a language other than English and need an interpreter for my hearing. (The state will provide the interpreter at no cost to you.)

Language _____ Dialect _____

Signature _____ Date _____

The information you provide on this form is needed to process your request for a hearing, and processing may be delayed if your request is incomplete. A case file will be set up by the Chief Referee. You have a right to examine the materials that make up the file and may do so by contacting Public Inquiry and Response. Any information you provide may be shared with the county welfare department, with the U.S. Department of Health and Human Services, or the U.S. Department of Agriculture. Authority: W&IC 10950.

IN—HOME SUPPORTIVE SERVICES (IHSS)

NOTICE OF ACTION

NOTE: *The action described below relates **ONLY** to your Social Services. It does **NOT** affect your receipt of SSI/SSP or Social Security.*

Case Number: _____

Date Mailed: _____

SPECIAL NOTICE

This is a special notice which is being sent to you concerning your In-Home Supportive Services. On _____ you were sent a notice from the county welfare department which either reduced or terminated your In-Home Supportive Services due to a change in State law. **That notice may not have properly and completely informed you of your right to request a state hearing and of your right to receive aid paid pending the state hearing.** PLEASE CAREFULLY READ ALL OF THE FOLLOWING NOTICE WHICH WILL GIVE YOU INFORMATION ON THE NATURE OF THE COUNTY WELFARE DEPARTMENT'S ACTION AND ITS EFFECT ON YOUR IN-HOME SUPPORTIVE SERVICES. If you have any questions after reading this information or believe other facts should be considered, please immediately call your Agency Representative.

Your In-Home Supportive Services (IHSS) were reduced to _____ hours and ($_____) per month effective _____. Prior to this reduction, you received _____ — _____ hours ($) per month. The changes are as follows:

	Hours per month before reduction	**Hours per month now allowed**
Domestic services: (Such as sweeping, garbage removal, putting away food and changing bed linen.)	_____	_____

The county welfare department has determined that the level of domestic services you have been granted will not result in your loss of employment, placement in a medical out-of-home care facility, a condition which threatens your life or a substantial threat to your health or safety. The determination regarding the number of hours allocated to you for domestic services was based on:

_____ You are the only person counted in your household.

_____ You are receiving a pro rata share of the entire domestic services allowance based on _____ people living in your household.

The action taken above was required by regulations **MPP 30-450 and 30-458.**

IF YOU DISAGREE WITH THE DETERMINATION WHICH RESULTED IN THE REDUCTION OR TERMINATION OF YOUR IHSS, SEE REVERSE SIDE OF THIS FORM FOR YOUR RIGHT TO REQUEST A STATE HEARING AND TO RECEIVE AID PAID PENDING THE HEARING.

_____ Agency Representative

_____ Telephone Number

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Aid paid pending will be effective as of the date of the County's original action.

You will not be liable for repayment of services or monies received pending the hearing, even if the result is a denial.

You can represent yourself at the state hearing. You can also be represented by a friend, attorney or any other person, but you are expected to arrange for the representative yourself. You can get help in locating free legal assistance by calling the toll-free number of Public Inquiry and Response.

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Toll-Free Number: (800) 952-5253 *

TDD (800) 952-8349* For the Deaf Only

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The State Public Inquiry and Response Unit can provide you with further information about your hearing rights or files or other welfare-related matters. Assistance is also available in some languages other than English, including Spanish. You may phone, write, or come in.

Public Inquiry and Response
State Department of Social Services
744 P Street, Mail Station 16-23
Sacramento, CA 95814

Request for a State Hearing

Name _____ Phone number ( )

Address _____ City _____ State _____ Zip code _____

I am requesting a state hearing because of an action by the welfare department of _____ county related to In-Home Supportive Services

Reasons for my request:

_____

_____

_____

_____

☐ I speak a language other than English and need an interpreter for my hearing. (The state will provide the interpreter at no cost to you.)

Language _____ Dialect _____

Signature _____ Date _____

The information you provide on this form is needed to process your request for a hearing, and processing may be delayed if your request is incomplete. A case file will be set up by the Chief Referee. You have a right to examine the materials that make up the file and may do so by contacting Public Inquiry and Response. Any information you provide may be shared with the county welfare department, with the U.S. Department of Health and Human Services, or the U.S. Department of Agriculture. Authority: W&IC 10950.

IN—HOME SUPPORTIVE SERVICES (IHSS)
NOTICE OF ACTION

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Case Number: _____

Date Mailed: _____

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Your In-Home Supportive Services (IHSS) were reduced to _____ hours ($ _____) effective _____ . Prior to this reduction, you received _____ hours ($ _____). The changes are as follows:

	Hours before reduction	**Hours now allowed**
Heavy Cleaning	_____	_____

This action was based on a new state regulation which provides that services for heavy cleaning shall only be authorized when IHSS is initially granted or when IHSS is restored and heavy cleaning has not been provided within the last 12 months.

The county welfare department has determined that the service reductions outlined above will not result in your loss of employment, placement in a medical out-of-home care facility, a condition which threatens your life or a substantial threat to your health or safety.

The above action was required by regulation MPP Section 30-457.2.

IF YOU DISAGREE WITH THE DETERMINATION WHICH RESULTED IN THE REDUCTION OR TERMINATION OF YOUR IHSS, SEE THE REVERSE SIDE OF THIS FORM FOR YOUR RIGHT TO REQUEST A STATE HEARING AND TO RECEIVE AID PAID PENDING THE HEARING.

_____ Agency Representative

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State Department of Social Services
744 P Street, Mail Station 16-23
Sacramento, CA 95814

Request for a State Hearing

Name _____ Phone number ( )

Address _____ City _____ State _____ Zip code _____

I am requesting a state hearing because of an action by the welfare department of _____ county related to In-Home Supportive Services

Reasons for my request:

☐ I speak a language other than English and need an interpreter for my hearing. (The state will provide the interpreter at no cost to you.)

Language _____ Dialect _____

Signature _____ Date _____

The information you provide on this form is needed to process your request for a hearing, and processing may be delayed if your request is incomplete. A case file will be set up by the Chief Referee. You have a right to examine the materials that make up the file and may do so by contacting Public Inquiry and Response. Any information you provide may be shared with the county welfare department, with the U.S. Department of Health and Human Services, or the U.S. Department of Agriculture. Authority: W&IC 10950.

IN—HOME SUPPORTIVE SERVICES (IHSS)
NOTICE OF ACTION

NOTE: *The action described below relates **ONLY** to your Social Services. It does **NOT** affect your receipt of SSI/SSP or Social Security*

Case Number: _____

Date Mailed: _____

Your In-Home Supportive Services authorization will be reduced to _____ hours ($ _____) effective _____. You are currently receiving _____ hours ($ _____). The changes are as follows:

	HOURS PER MONTH BEFORE REDUCTION	HOURS PER MONTH AFTER REDUCTION
Domestic services: (Such as sweeping, garbage removal, putting away food and changing bed linen.)		
Related services: (Those services related to domestic, such as shopping, preparation of meals and cleanup and laundry.)		
Transportation: (Such as transportation to necessary medical appointments and other necessary travel.)		
Protective Supervision: (Observing behavior in order to safeguard against injury or accident.)		
Other: (specify) _____		

The county welfare department has determined that:

1. You have a spouse living in your home;
2. Your spouse does not have medical verification of inability to perform services;
3. Your spouse is not away from your home for employment or for health reasons during the time that meal preparation, transportation and protective supervision are required;
4. This reduction would not result in your loss of employment or placement in a medical out-of-home care facility.

This reduction is the result of a new state regulation. This regulation requires that when an able spouse in the home is available to assist you, the state cannot pay your spouse or any other provider for any IHSS services other than nonmedical services and paramedical services. (Nonmedical personal services are services such as bowel and bladder care, feeding, routine bed baths and dressing. Paramedical services are services which are ordered by a licensed health care professional.)

The above action was required by regulation MPP Section 30-463.24.

If you have any questions after reading this information or believe other facts should be considered, please immediately call your Agency Representative.

IF YOU DISAGREE WITH THE DETERMINATION WHICH RESULTED IN THE REDUCTION OR TERMINATION OF YOUR IHSS, SEE THE REVERSE SIDE OF THIS FORM FOR YOUR RIGHT TO REQUEST A STATE HEARING AND TO RECEIVE AID PAID PENDING THE HEARING.

_____ Agency Representative

_____ Telephone Number

Your Right to Appeal This Action

If you are dissatisfied with the County's original action, you may request a state hearing before a Hearing Officer of the State Department of Social Services even though your original notice may have led you to believe otherwise. This hearing will be conducted in an informal manner to assure that everyone present is able to speak freely. If you decide to request a state hearing, you may do so within **90 DAYS OF THE MAILING OF THIS NOTICE.**

IF YOU ASK FOR A HEARING BEFORE THE EFFECTIVE DATE OF THIS ACTION, YOU WILL RECEIVE AID PAID PENDING THE STATE HEARING, AT THE LEVEL OF SERVICES YOU ARE CURRENTLY RECEIVING.

You will not be liable for repayment of services or monies received pending the hearing, even if the result is a denial.

You can represent yourself at the state hearing. You can also be represented by a friend, attorney or any other person, but you are expected to arrange for the representative yourself. You can get help in locating free legal assistance by calling the toll-free number of Public Inquiry and Response.

How to Request a State Hearing

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Public Inquiry and Response
State Department of Social Services
744 P Street, Mail Station 16-23
Sacramento, CA 95814

Request for a State Hearing

Name _____ Phone number ( )

Address _____ City _____ State _____ Zip code

I am requesting a state hearing because of an action by the welfare department of _____ county related to In-Home Supportive Services

Reasons for my request:

☐ I speak a language other than English and need an interpreter for my hearing. (The state will provide the interpreter at no cost to you.)

Language _____ Dialect _____

Signature _____ Date _____

The information you provide on this form is needed to process your request for a hearing, and processing may be delayed if your request is incomplete. A case file will be set up by the Chief Referee. You have a right to examine the materials that make up the file and may do so by contacting Public Inquiry and Response. Any information you provide may be shared with the county welfare department, with the U.S. Department of Health and Human Services, or the U.S. Department of Agriculture. Authority: W&IC 10950.

IN—HOME SUPPORTIVE SERVICES (IHSS)

NOTICE OF ACTION

NOTE: *The action described below relates **ONLY** to your Social Services. It does **NOT** affect your receipt of SSI/SSP or Social Security.*

Case Number: _____

Date Mailed: _____

Your In-Home Supportive Services authorization will be reduced to _____ hours ($_____) effective _____. You are currently receiving _____ hours ($ _____). The changes are as follows:

	HOURS PER MONTH BEFORE REDUCTION	HOURS PER MONTH AFTER REDUCTION
Domestic services: (Such as sweeping, garbage removal, putting away food and changing bed linen.)	_____	_____

The county welfare department has determined that the domestic services you have been granted will not result in your loss of employment, placement in a medical out of home care facility, a condition which threatens your life or a substantial threat to your health or safety. The determination regarding the number of hours allocated to you for domestic services was based on:

_____ You are the only person counted in your household.

_____ You are receiving a pro rata share of the entire domestic services allowance based on _____ people living in your household.

The action taken above was required by regulations **MPP 30-450 and 30-458.**

If you have any questions after reading this information or believe other facts should be considered, please immediately call your Agency Representative.

IF YOU DISAGREE WITH THE DETERMINATION WHICH RESULTED IN THE REDUCTION OR TERMINATION OF YOUR IHSS, SEE REVERSE SIDE OF THIS FORM FOR YOUR RIGHT TO REQUEST A STATE HEARING AND TO RECEIVE AID PAID PENDING THE HEARING.

_____ Agency Representative

_____ Telephone Number

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IF YOU ASK FOR A HEARING BEFORE THE EFFECTIVE DATE OF THIS ACTION, YOU WILL RECEIVE AID PAID PENDING THE STATE HEARING, AT THE LEVEL OF SERVICES YOU ARE CURRENTLY RECEIVING.

You will not be liable for repayment of services or monies received pending the hearing, even if the result is a denial.

You can represent yourself at the state hearing. You can also be represented by a friend, attorney or any other person, but you are expected to arrange for the representative yourself. You can get help in locating free legal assistance by calling the toll-free number of Public Inquiry and Response.

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744 P Street, Mail Station 16-23
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Request for a State Hearing

Name _____ Phone number ( )

Address _____ City _____ State _____ Zip code

I am requesting a state hearing because of an action by the welfare department of _____ county related to In-Home Supportive Services

Reasons for my request:

☐ I speak a language other than English and need an interpreter for my hearing. (The state will provide the interpreter at no cost to you.)

Language _____ Dialect _____

Signature _____ Date _____

The information you provide on this form is needed to process your request for a hearing, and processing may be delayed if your request is incomplete. A case file will be set up by the Chief Referee. You have a right to examine the materials that make up the file and may do so by contacting Public Inquiry and Response. Any information you provide may be shared with the county welfare department, with the U.S. Department of Health and Human Services, or the U.S. Department of Agriculture. Authority: W&IC 10950.

IN—HOME SUPPORTIVE SERVICES (IHSS)
NOTICE OF ACTION

NOTE: *The action described below relates **ONLY** to your Social Services. It does **NOT** affect your receipt of SSI/SSP or Social Security.*

Case Number: _____

Date Mailed: _____

Your In-Home Supportive Services authorization will be reduced to _____ hours ($ _____) effective _____ . You are currently receiving _____ hours ($ _____). The changes are as follows:

	HOURS PER MONTH BEFORE REDUCTION	HOURS PER MONTH AFTER REDUCTION
Heavy Cleaning	_____	_____

This action was based on a new state regulation which provides that services for heavy cleaning shall only be authorized when IHSS is initially granted or when IHSS is restored and heavy cleaning has not been provided within the last 12 months.

The county welfare department has determined that the service reduction outlined above will not result in your loss of employment, placement in a medical out of home care facility, a condition which threatens your life or a substantial threat to your health or safety.

The above action was required by regulation MPP Section 30-457.2.

If you have any questions after reading this information or believe other facts should be considered, please immediately call your Agency Representative.

IF YOU DISAGREE WITH THE DETERMINATION WHICH RESULTED IN THE REDUCTION OR TERMINATION OF YOUR IHSS, SEE THE REVERSE SIDE OF THIS FORM FOR YOUR RIGHT TO REQUEST A STATE HEARING AND TO RECEIVE AID PAID PENDING THE HEARING.

_____ Agency Representative

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You can represent yourself at the state hearing. You can also be represented by a friend, attorney or any other person, but you are expected to arrange for the representative yourself. You can get help in locating free legal assistance by calling the toll-free number of Public Inquiry and Response.

How to Request a State Hearing

The best way to request a hearing is to fill in and send this entire notice to:

Office of the Chief Referee
State Department of Social Services
744 P Street, Mail Station 6-100
Sacramento, CA 95814

You may also request a hearing by calling the toll-free number of Public Inquiry and Response.

Public Inquiry and Response (Public Information)

Toll-Free Number: (800) 952-5253 *

TDD (800) 952-8349* For the Deaf Only

*You may have to dial "1" first.

The State Public Inquiry and Response Unit can provide you with further information about your hearing rights or files or other welfare-related matters. Assistance is also available in some languages other than English, including Spanish. You may phone, write, or come in.

Public Inquiry and Response
State Department of Social Services
744 P Street, Mail Station 16-23
Sacramento, CA 95814

Request for a State Hearing

Name _____ Phone number ( )

Address _____ City _____ State _____ Zip code

I am requesting a state hearing because of an action by the welfare department of _____ county related to In-Home Supportive Services

Reasons for my request:

☐ I speak a language other than English and need an interpreter for my hearing. (The state will provide the interpreter at no cost to you.)

Language _____ Dialect

Signature _____ Date

The information you provide on this form is needed to process your request for a hearing, and processing may be delayed if your request is incomplete. A case file will be set up by the Chief Referee. You have a right to examine the materials that make up the file and may do so by contacting Public Inquiry and Response. Any information you provide may be shared with the county welfare department, with the U.S. Department of Health and Human Services, or the U.S. Department of Agriculture. Authority: W&IC 10950.

In each case you must use the forms that have been identified below:

Non-Severely Impaired:

TEMP 1495	Able and Available Spouse
TEMP 1496	Domestic Services
TEMP 1497	Heavy Cleaning

Severely Impaired:

TEMP 1508	Able and Available Spouse
TEMP 1509	Domestic Services
TEMP 1510	Heavy Cleaning

INSTRUCTIONS FOR PROCESSING INDIVIDUAL PROVIDER CASE PAYMENTS ORDERED IN DISABLED UNION V. WOODS

The payrolling system has been programmed to code restoration and retroactive pay.

1. Use the SOC 311 for restoration actions. Enter Reason Code 633 (increase due to restoration per court order). This code applies to:

   a) Severely impaired recipients restored by the Temporary Restraining Order.

   b) Non-severely impaired recipients who, upon receipt of special SB 633 renotices, file timely hearing requests and thereby receive aid paid pending from the effective date of the county's original SB 633 action. Code 633 will apply to the increase in service level required for "continuing" aid paid pending.

2. Use the SOC 312 for payments of retroactive restoration or retroactive aid paid pending. Issue payment using the Emergency Transaction Code and enter Reason Code X-09 (court ordered payment). Since this payment will be paid to IHSS recipients only, taxes will not be deducted.

These instructions incorporate and expand upon those provided with ACL 81-110.

If you have any questions, please contact your IHSS Payroll Consultant at (916) 323-0270 or ATSS 473-0270.